

NATIONAL INSTITUTES OF HEALTH
WARREN GRANT MAGNUSON CLINICAL CENTER
NURSING DEPARTMENT

SOP: Transfer of a Patient to the O.R.

I. ASSESSMENT

A. Review Medical Record

1. Medical Record review will begin as soon as operative procedure has been scheduled
2. Review physician orders for:
 - a. NPO status
 - b. Preoperative medications (sedatives, antibiotics, etc.)
 - c. Status of routine medications
 - IDDM and NIDDM medications
 - Cytotoxic agents
 - Investigational agents
 - Others as ordered
 - d. Laboratory work
 - e. Intravenous hydration
 - f. Sequential Compression Device and/or TEDS
3. Consents are signed, dated, and witnessed prior to administration of sedatives/anxiolytics
 - a. Request for Administration of Anesthesia and for Performance of Operation and Other Procedures
 - b. Protocol consent
 - c. Consent for Transfusion of Blood Components, if applicable
 - d. Sterilization consent, if applicable
4. Preoperative diagnostic study reports are available on chart
 - a. Lab work, as ordered by prescriber
 - b. Type and Cross Match within 72 hours, if applicable
 - c. Chest X-Ray within 72 hours or, as ordered by prescriber
5. EKG report or tracing
 - a. Patients over 40 years of age EKG within 1 month
 - b. Patients with a history of cardiac disease EKG within 1 month
6. Labels on chart
 - a. Addressograph labels
 - b. Allergy labels, if appropriate
 - c. Isolation labels, if appropriate

- d. Radioactive labels, if appropriate

B. Patient Assessment

1. Hospital identification bracelet is accurate and legible
2. Typenex[®] band (if applicable) is current and legible
3. Allergy band (if applicable) is current and legible
4. Attire
 - a. Undergarments have been removed
 - b. Wearing non wrap-around hospital gown
 - c. All jewelry (including religious and body piercing jewelry) has been removed and secured. Ring cutter (if necessary) is available in CHS
 - d. Hair ornaments, wigs, and/or hair pieces have been removed
 - e. Make-up and nail polish have been removed; consult with anesthesia to determine if acrylic nails should be removed
 - f. Dentures (partial and full plates), prostheses, hearing aids, contact lens, and glasses have been removed and secured
 - g. Menstruating females will have tampons removed and peri pads in place without belt
 - h. Patients with ostomy appliances will have extra pouch on chart
5. Patient/Family learning needs
 - a. Operative procedure
 - b. Preoperative preparation (diagnostic tests, medications, NPO status, etc.)
 - c. Recovery phase (ICU vs PACU, OR and/or unit tours, length of recovery)
 - d. Postoperative (lifestyle changes, anticipated equipment and/or appliances)

II. INTERVENTIONS

A. Patient Preparation

1. Initiate patient/family teaching as soon as operative procedure has been scheduled:
 - a. Operative procedure
 - b. Preoperative preparation (diagnostic tests, medications, NPO status, etc.)
 - c. Recovery phase (ICU vs PACU, OR and/or unit tours, length of recovery)
 - d. Post-operative (lifestyle changes, anticipated equipment and/or appliances)
2. Prior to administration of preoperative sedatives:
 - a. Measure vital signs, obtain weight and height.
 - b. Assist patient to void
 - c. Ensure consents have been signed and witnessed
3. Administer ordered preoperative medications
 - a. If IV access required for pre-medications, adult patients will have an 18 g angiocath placed by RN; pediatric patients will have the largest gauge angiocath possible placed based on age and size.

- b. Medications (antibiotics, sedatives, etc.) ordered as “ON-CALL” will be given when the OR staff call nursing unit for the patient; if administering an agent known to induce minimal sedation (anxiolysis), monitor oxygen saturation continuously (per M92-9: Administration of Sedation)
 - c. Medications (antibiotics, sedatives, etc.) ordered as “MORNING OF SURGERY” will be given at 7:00 a.m.
 - d. Medications ordered for “TO FOLLOW” cases will be placed on unit chart unless otherwise notified by OR staff
 - B. Chart preparation morning of operative procedure
 - 1. Gather medical record, and unit chart
 - 2. Attach addressograph plate to medical record
 - 3. If patient has ostomy appliance, include clean ostomy pouch on chart
 - 4. Print and attach Interim Summary (“12 Midnight to Now”) to chart after completion of documentation
 - 5. Include “on-call” medications with unit chart
 - 6. Completed OR Checklist on front of unit chart
 - 7. Pediatric Emergency Drug Sheet on front of unit chart
 - C. Transport patient to OR
 - 1. All patients scheduled for 8:00 a.m. will be ready for transport by 7:00 a.m.
 - 2. Patients going to the OR will be accompanied by nursing unit personnel and OR Health Technician
 - 3. Intravenous infusions will be monitored and maintained by nursing unit personnel; infusion pumps will be removed in the OR receiving area and returned to nursing unit personnel
 - 4. Pediatric patients will be transported to the OR in a crib or stretcher as provided by the OR; parent may accompany child
 - 5. Prepare patient’s room for return from PACU
 - a. IV equipment
 - b. Clean bed linen
 - c. Bed in high horizontal position

III. DOCUMENTATION

- A. OR Checklist
 - 1. Initiate as soon as operative procedure has been scheduled and complete immediately prior to transport from the PCU.
 - 2. All RNs documenting on the OR Checklist will initial in the appropriate area and sign, date/time document
- B. MIS
 - 1. Vital Signs (BP, TPR, oxygen saturation), height and weight
 - 2. Current assessment
 - 3. “To the OR” note (Nursing Master Guide / To the OR / OR Transfer Note and To the OR Surg

IV. REFERENCES

- A. Association of Operating Room Nurses (2001). Standards, Recommended Practices and Guidelines, Denver: Association of Operating Room Nurses, Inc.
- B. Fairchild, S. (1993). Perioperative Nursing, p. 286-297 Boston: Jones and Bartlett Publishers
- C. Meeker, M. and Rothrock, J. (1995). Alexander’s Care of the Patient in Surgery, St. Louis: Mosby Year Book, Inc.

- D. Medical Administrative Manual Series
1. M77-2: Informed Consent
 2. M92-2: Policy of Voluntary Sterilization of Clinical Center Patients
 3. M93-7: Patient Identification and Bracelet
 4. M92-9: Administration of Sedation

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